TCHP – GENERAL INFORMATION

Overview

TCHP is a traditional indemnity plan which offers a comprehensive range of benefits. Under TCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using Preferred Provider Organization (PPO) hospitals and physicians, network pharmacies for prescription drugs and mental health/substance abuse providers authorized by the mental health/substance abuse plan administrator.

Plan Components

- **TCHP is comprised of three independent components:**
  - Medical.
  - Prescription Drugs.
  - Mental Health/Substance Abuse Treatment Services.

It is not necessary to satisfy the plan year deductible in order to start receiving benefits for prescription drugs or mental health/substance abuse services. These programs are not subject to out-of-pocket maximums. However, these programs are applied towards the lifetime maximums.

Each of these three components is discussed separately in this chapter. Please note that each component has its own plan administrator. See Chapter 3, Section entitled Plan Administrators.

Plan Features

Plan Participant Responsibilities

- **The Plan Participant is always responsible for:**
  - Any amount required to meet **plan year deductibles, special deductibles** and **coinsurance amounts**.
  - Any amount over **Usual and Customary (U&C)**.
  - Any penalties for failure to comply with the **Notification Requirements.**
  - Any charges not covered by the Plan or not determined by the TCHP Plan Administrator to be **medically necessary** services.

Plan Year Deductible

The plan year deductible must first be satisfied before benefits begin. This deductible requirement applies to all services unless otherwise noted. The plan year deductible applies toward satisfying the out-of-pocket maximums as well.

Each covered person has a plan year deductible of $250 that must be satisfied. Each plan year begins on July 1.

Special Deductibles

In addition to the plan year deductible, plan participants must pay a special deductible of **$250** for each emergency room visit that does not result in a hospital admission. A special deductible of **$250** will apply for each admission to a non-PPO hospital. The deductible is waived for admission to a PPO hospital or for medically necessary transfers.

These special deductibles accumulate toward the annual out-of-pocket maximums, but do not satisfy the plan year deductible. **See page 37 for details.**

Coinsurance

After the plan deductible has been met, the Plan generally pays most of the cost of services or supplies; but plan participants must pay a percentage (called coinsurance) on most bills. Plan participants may be responsible for applicable co-insurance of eligible professional charges for a physician's office visit.

Plan Year Maximum Out-of-Pocket Expenses

There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles count toward one or the other, but not toward both. See the Section entitled Medical Benefits Summary in this chapter.

General Out-of-Pocket Maximum – The amounts paid toward deductibles and coinsurance, except for charges related to a non-PPO hospital/facility, accumulate toward satisfying the out-of-pocket maximum.

After the general out-of-pocket maximum has been met, coinsurance amounts are no longer required and the Plan pays 100% of eligible charges for the remainder of the plan year.

Non-PPO Out-of-Pocket Maximum – The amounts paid toward deductibles and coinsurance at a non-PPO hospital/facility accumulate toward satisfying the non-PPO out-of-pocket maximum.

Eligible Charges

- **TCHP provides benefits for eligible charges only. Eligible charges for those covered services and supplies which are:**
  - Medically necessary.
  - Based on Usual and Customary (U&C).

Medical Necessity

- **TCHP covers charges for services and supplies that are medically necessary. Medically necessary services or supplies are those which are:**
  - Provided by a hospital, prescribed by a physician, or other provider and are required to identify and/or treat an illness or injury.
  - Consistent with the symptoms or diagnosis and treatment of the condition (including pregnancy), disease, ailment or accidental injury.
  - Generally accepted in medical practice as necessary and meeting the standards for good medical practice for the diagnosis or treatment of the patient's condition.
  - The most appropriate supply or level of service which can be safely provided to the patient.
  - Not solely for the convenience of the patient, physician, hospital or another provider.
  - Repeated only as indicated as medically appropriate.
  - When specifically applied to a confinement, it further means that the patient's medical symptoms, condition, diagnosis or treatment cannot be safely provided as outpatient.
  - Not redundant when combined with other treatment being rendered.

For determination of medically necessary services or supplies, contact the appropriate plan administrator in writing to request a pre-determination.

Usual and Customary (U&C)

U&C is an amount determined by the Medical Plan Administrator not to exceed the general level of charges being made by providers in the locality where the charge is incurred when furnishing like or similar services, treatment or supplies for a similar medical condition. U&C applies to professional fees and some other services.

If a charge exceeds U&C, the plan participant is responsible for the portion of the expense that is above U&C. Amounts in excess of U&C are not eligible and are not applicable to plan year deductible or out-of-pocket maximum.

IMPORTANT: The percentage of the claim that will be paid is always based on U&C or the actual charge made by the provider, whichever is less.

Preferred Provider Organization (PPO) Hospital Networks

The Hospital PPO Networks include hospitals nationwide and throughout Illinois. The network is subject to change. Refer to the annual Benefit Choice Options Booklet for information on network PPO hospitals.

PPO hospitals provide quality care at reduced rates, which can result in significant savings to plan participants. The benefit level for inpatient services and outpatient surgery when utilizing a PPO hospital is 80% of the negotiated rate, rather than 60% of U&C. In addition, there is no admission deductible for inpatient care rendered at a PPO hospital.

A 60% benefit level will apply if a plan participant utilizes a non-PPO hospital when a TCHP PPO hospital is located within the same travel distance. Although any hospital may be used for inpatient services and outpatient surgery, the enhanced benefit of 80% is received only when utilizing a PPO network hospital.

Should the negotiated PPO rate exceed the actual charges, contact CMS/Group Insurance Division in writing to request a review.

Exceptions to the PPO Hospital Network

Any hospital may be used for inpatient or outpatient services, but enhanced benefits are received at a PPO network hospital.

Exceptions to the non-PPO benefit of 60% are evaluated by the Notification Administrator, upon request, when emergency or specialized care is required but not available at the TCHP PPO hospital. If an exception is granted, the benefit is 70% of U&C. If an exception is not granted, the non-PPO 60% benefit will apply.

If a plan participant chooses to travel more than 25 miles and a TCHP PPO hospital is available within the same travel distance, a TCHP PPO hospital must be used or the 60% benefit will apply.

Medical Case Management

TCHP has a benefit called the Medical Case Management (MCM) Program. MCM is designed to assist the plan participant requiring complex care in times of serious or prolonged illness.

If a plan participant is confronted with such illness, an MCM case manager will help find appropriate treatment to ensure maximum benefits under the Plan. Involvement in MCM has proven to enhance benefits based on an evaluation of the individual's needs. MCM is part of the benefits under TCHP. There is no cost to the plan participant for this service.

The referral to the MCM Program is made through either the MCM Administrator, the Medical Plan Administrator or by request from a plan participant. The MCM case manager serves as a liaison and facilitator between the patient, family, physician and health care facility. This case manager is a Registered Nurse or other health care professional with extensive clinical background. The MCM case manager can effectively minimize the fragmentation of care so often encountered within the health care delivery system in response to complex cases.

Upon completing the MCM review, the MCM case manager will make a recommendation regarding the treatment setting, intensity of services and appropriate alternatives of care. **Refusal to participate in the MCM Program will result in a reduction or denial of benefits available under the Plan for treatment of the illness for which the plan participant was referred to MCM.**

To reach the MCM Administrator, call the toll-free number listed in Chapter 3, Section entitled Plan Administrators.

Coordination of Benefits (COB)

If TCHP is primary, benefits will be paid without regard to the other plan's benefits.

- **If the other plan is primary, benefits under the plan will be determined in the following manner:**
  - TCHP will first determine what would have been paid in the absence of any other coverage, subject to applicable deductibles and coinsurance.
  - If a balance due remains after the primary carrier has paid, TCHP will pay that balance *up to* the maximum amount calculated above.

Coordinating Medical Coverage with Medicare

Individuals may qualify for Medicare in a number of ways including age, disability and End-Stage Renal Disease. The issue of whether Medicare pays first, referred to as the primary payer, depends on the employment status of the Member and the reason for receiving Medicare.

When Medicare is primary, TCHP coordinates with Medicare. The TCHP becomes primary for eligible services or supplies not covered by Medicare, or after Medicare benefits have been exhausted. See Notification Requirements in this section.

Part A – Hospital Insurance

- **After Medicare Part A pays, TCHP pays:**
  - All but $50 of the Medicare Part A deductible.
  - Medicare Part A coinsurance.
  - Hospital and Skilled Extended Care Facility stays beyond the maximum days allowed under Medicare, provided that the care satisfies the TCHP criteria of medical necessity and skilled care.

NOTE: All Medicare lifetime reserve days must be used before TCHP will become primary payer.

Part B Medical Insurance

- **After Medicare Part B pays, TCHP pays:**
  - All of the Medicare Part B deductible.
  - The Medicare Part B coinsurance in full.
  - If the provider accepts Medicare assignment, TCHP pays the 20% of approved charges which Medicare does not cover. If the provider does not accept Medicare assignment, TCHP pays all amounts Medicare does not cover, up to the maximum limiting charges set by Medicare.
  - There are limitations on coverage under TCHP if the plan participant does not purchase Medicare Part B coverage.
- **Services and supplies not covered by Medicare:**
  - TCHP pays standard benefits for services and supplies if they meet benefit criteria and would normally be covered if the plan participant does not have Medicare (annual TCHP deductible applies).

Medicare Crossover - Part B Only

Medicare will automatically and electronically forward processed Part B claim(s) to the Medical Plan Administrator. This is known as "Medicare Crossover." The plan participant must provide the Medicare Individual Claim Number (ICN) to the Medical Plan Administrator. Once the ICN is received, the Medical Plan Administrator can receive claim(s) determination information directly from Medicare, and then process Medicare Part B claims according to plan provisions.

Medicare Crossover applies to Part B claims only. Part A claims must continue to be submitted with the Medicare Explanation of Benefits to the Medical Plan Administrator.

IMPORTANT: Questions regarding Medicare Crossover should be directed to the Medical Plan Administrator. Questions regarding eligibility and enrollment for Medicare should be directed to the Social Security Administration.

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or extended care facility or for other services, such as mental health or specified outpatient procedures. Notification is the plan participant's responsibility and is a method to avoid penalties and maximize benefits.

Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare. Failure to notify the Plan within the required time limits will result in a $1,000 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

Notification is the plan participant's responsibility. Whenever possible, make the initial telephone call to the Notification Administrator, rather than relying on someone else to do this.

- **The Notification Administrator will need the following information:**
  - Patient's name, address and date of birth.
  - Member's name, address and Social Security number.
  - Date of admission, if known, or expected due date of maternity admission.
  - Diagnosis or procedure.
  - Physician's name, address and telephone number (including area code).
  - Hospital or extended care facility name, address and telephone number (including area code).

A "reference number" will be assigned and should be maintained in the plan participant's records. This number serves as a resource should there be any questions regarding notification. The Notification Administrator maintains detailed records on every call when the plan participant's enrollment status is verified.

After notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

- **Notification is required for the following:**
  - **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
  - **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. **Notification of a maternity admission is not automatic enrollment of the newborn.** Contact TRS to enroll the newborn.
  - **Skilled Nursing Facility, Extended Care Facility or Nursing Home Admission** - At least seven days before admission, call the Notification Administrator. A review of the care being rendered will be conducted to determine if the services are skilled in nature.
  - **Emergency or Urgent Admission** - The plan participant or physician must contact the Notification Administrator within two business days after the admission.
  - **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
  - **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the

first indication that a transplant may be necessary. **Benefits are available through the Transplant Preferred Provider Organization (TPPO) Network and must be authorized by the Notification Administrator.**

- **Notification is not:**
  - **A final determination of medical necessity -** Health conditions and need for treatment can change quickly. If the Notification Administrator should determine that the stay is no longer medically necessary and not eligible for coverage, the physician will be informed immediately. The plan participant will also receive written confirmation of this determination.
  - **A guarantee of benefits** - Regardless of notification of a procedure or admission, if the plan participant is ineligible for coverage on the date services were rendered or if the charges were ineligible there will be no benefits payment.
  - **Enrollment of a newborn for coverage** Contact TRS to enroll a newborn within 31 days of birth. **Notification of a maternity admission does not mean the newborn is automatically enrolled.**

NOTE: For notification procedures and time limits for mental health/substance abuse services, see Chapter 2, Section entitled Mental Health/Substance Abuse.

To call the Notification Administrator, see Chapter 3, Section entitled Plan Administrators. The toll-free number is also printed on your identification card and in the annual Benefit Choice Options Booklet. You can call seven days a week, 24 hours a day.

Pre-Determination of Benefits

Pre-determination is a method to ensure that medical services will meet medical criteria and be eligible for benefit coverage.

The plan participant's physician must submit written detailed medical information to the Medical Plan Administrator. For questions regarding a pre-determination of benefits, contact the Medical Plan Administrator.